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Incorporation By Reference

MAP 9, Prior Authorization for Health Services
December 1995 edition
(Clean Copy)

MAP 9A, Kentucky Medicaid Program Orthodontic Services Agreement
December 1995 edition
(Clean Copy)

MAP 306, Temporomandibular Joint (TMJ) Assessment Form
December 1995 edition
(Clean Copy)

MAP 396, Kentucky Medicaid Orthodontic Evaluation Form
March 2001 edition
(Clean Copy)

MAP 559, Six (6) Month Orthodontic Progress Report
December 1995 edition
(Clean Copy)

MAP 700, Kentucky Medicaid Program Orthodontic Final Case Submission
December 1995 edition
(Clean Copy)

Dental Manual
August 1998 Edition
(Dirty Copy)

Filed October 16, 2003

Cabinet for Health Services
Department for Medicaid Services
275 East Main Street
Frankfort, Kentucky 40621

MAP-9 (Rev. 12/95)

COMMONWEALTH OF KENTUCKY
CABINET FOR HUMAN RESOURCES
KENTUCKY MEDICAID PROGRAM
PRIOR AUTHORIZATION FOR HEALTH-SERVICES

1. Med. Assist. I.D. No. (Ten Digits)	2. Recipient Last Name:	3. First Name:	4. M.I.

5a: Provider Number (Eight Digits)	6a. Provider Name, Address, and Phone Number	7. Co. # of Recipient Residence:
5b. Provider Number (Eight Digits)	6b. Provider Name, Address, and Phone Number	8. Date of Delivery (if already delivered)

9. Primary Diagnosis:	11. Date of Birth
10. Secondary Diagnosis:	MM DD YYYY

Signature of Provider:	Date:	**Caution**: In order for you to receive payment, the recipient must be eligible on the date of service. **Check The Medicaid Card.**

12. Line No.	13. Procedure/ Supply Description	14. Procedure Supply Code	15. Units of Service	16. Usual and Customary Charges	17. Medicaid Action A =Approved D=Disapproved	18. Approved Amount*
01.						
02.						
03.						
04.						
05.						
06.						

19. HCB and Model Waiver Providers enter Approximate Total Monthly Charge:

$_____

DO NOT WRITE BELOW THIS LINE

20. Reason For Denial:

21. Other Comments:

22. Prior Authorization Number:	23. Approval Dates:	24. Type of Service Authorized:
Mailroom Use:	From: _____ Through: _____	40____DME 41____MODEL WAIVER 45____EPSDT/SPECIAL SERVICE 46____HOME HEALTH 52____H.C.B. 52 & 53 ____H.C.B & A.D.C 72____DENTAL ____OTHER
*Not used by H.C.B Waiver/Model Waiver		

Signature of Medicaid/Prior Authorization Respresentative:

Date:

MAP - 9A (Rev. 12/95)

KENTUCKY MEDICAID PROGRAM ORTHODONTIC SERVICES AGREEMENT

The Kentucky Medicaid Program and _____,
a participating provider of orthodontic services, mutually agree to the following:

1. Comprehensive orthodontic services have been pre-authorized for _____
_____, a currently eligible Medicaid recipient;

2. In return for an initial fee as specified by the Department for Medicaid Services, and effective upon receipt of such fee, the above-named provider agrees to provide the pre-authorized treatment as specified in the approved treatment plan;

3. If the recipient moves from the initial provider's medical service area after the banding and appliances are placed, making necessary a change in providers, the initial provider agrees to submit a patient referral form accompanied by a letter outlining treatment status: 1) dates seen, 2) treatment given, 3) progress made with prorated fee to Unisys. This informaton will be used by the orthodontic consultants to determine a prorated fee for the services provided;

4. As part of the aforementioned initial fee, the provider agrees to provide, at no additional cost to the Department or the recipient, all retainers necessary to complete the Phase of treatment;

5. Pre-authorizatons will not be approved unless the recipient's teeth have been properly cleaned and all general dentistry, i.e., fillings, root canals, etc., have been completed;

6. If the recipient or former recipient fails to return for the visits, the provider must initiate three (3) written contacts, or two (2) written and two (2) verbal (telephone) contacts, with the patient and/or his/her family, to solicit the patient's return to treatment. The final contact must be by certified letter with the returned receipt retained in the patient record. If a patient fails to respond to the contacts, the provider is relieved of the responsibility for providing retention services unless the patient returns for such services within (6) months of the last contact by the provider;

7. The provider will submit to the Medicaid Program beginnning and finished records consisting of: a panoramic x-ray, a cephalometic x-ray with tracing , intraoral and extraoral facial pictures (both frontal and profile), and properly occluded and trimmed models at the conclusion of the required course of of treatment. Failure to submit finished records within three (3) months after completion of treatment will result in a request for recoupment of payments made to the provider. Additional measures may be made to remove the provider from the Orthodontic Program.

Signature:_____ By Agency Representative:_____
Participating Provider

Date:_____ Date:_____
License Number:_____ Title:_____

MAP - 306 REV (12/95)

KENTUCKY MEDICAID PROGRAM
TEMPOROMANDIBULAR JOINT (TMJ) ASSESSMENT FORM

PROVIDER NAME & NUMBER_____

RECIPIENT NAME & NUMBER_____

DATE OF BIRTH_____

1. What is the patient's chief complaint?_____
_____
_____

2. Describe pain associated with chief complaint?_____
_____
_____

3. What is the duration of the chief complaint?_____

4. What is the history of the underlying chief complaint?_____
_____
_____

5. Has there been any previous treatment for the chief complaint? ( ) YES ( ) NO
If yes describe:_____
_____
_____

6. Is there pain associated with jaw functions (opening, closing, chewing, etc.) ( ) YES ( ) NO
Explain:_____
_____
_____

7. How wide can the patient open without pain? _____mm

8. How wide can the patient open maximally? _____mm

9. How far can the patient move the mandible eccentricty? Left _____ mm Right_____mm

10. Are there any TMJ sounds? ( ) YES ( ) NO If yes, at what distance during opening?
Left_____mm Right_____mm
At what distance during closing? Left _____mm Right _____mm
Is there pain associated with the joint sounds? ( ) YES ( ) NO

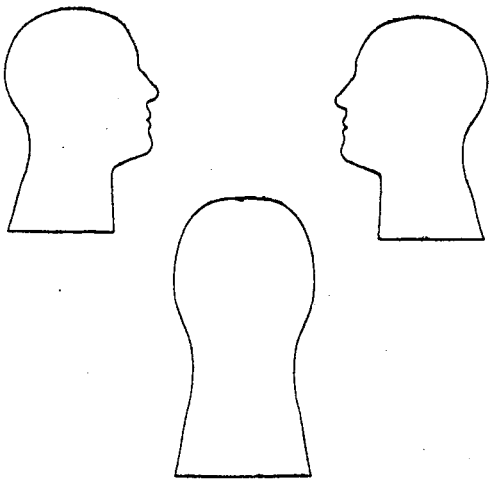
ATTENTION: Procedure 07880 is limited to recipients under the age of 21. Recipient must be Medicaid eligible and under 21 on the date of placing the splint for procedure to be covered. Providers are responsible to verify age and eligibility. NO EXCEPTIONS MADE.

11. Other medical, psychological or social factors that contribute to this condition?_____

12. What are the specific diagnosies?_____

13. What is your proprosed treatment and expected follow-up?_____

14. What is the expected cost of the treatment?_____



Place an "X" on areas that are reported painful during palpation.

MAP-396 (REV. 03/01)

KENTUCKY MEDICAID PROGRAM
ORTHODONTIC EVALUATION FORM

Date of Records/Examination _____ Date Received _____

I. Approval_____ Disapproval _____ Total Treatment Fee_____

II. Patient Information:

A. Name _____ Birthdate _____
Parent or Legal
Guardian _____
Address _____
Telephone _____
Sex _____ Racial/Ethnic Group _____

B. KY Medical Assistance Card Number _____

C. Chief Complaint _____

D. Pertinent Medical and Dental History:

II. Clinical Examination:

V. Radiographic Examination:

Radiographic Examination:

V. Cast Analysis:

VI Summary:

A. Prioritized Problem List:

B. Treatment Plan:

MAP 559 (REV.12/95)

KENTUCKY MEDICAID PROGRAM

6 MONTH ORTHODONTIC PROGRESS

PATIENT IN ACTIVE TREATMENT

DATE_____

PROVIDER NAME _____ PROVIDER NUMBER_____

PROVIDER TOTAL FEE (FOR TREATMENT)_____

STREET ADDRESS_____

CITY, STATE AND ZIP_____

PHONE NUMBER_____

PATIENTS NAME _____ M.A.I.D. #_____

PRIOR- AUTHORIZATION # (INTIAL SUBMISSION)_____

BANDING DATE (START OF TREATMENT)_____

MONTH DAY YEAR

DATE	TREATMENT(SPECIFY EXACT PROCEDURE)

[] TREATMENT IS PROGRESSING WELL AND IS ON SCHEDULE. (PLEASE LIST PATIENT VISITS ABOVE.)

[] TREATMENT IS BEHIND SCHEDULE. (IF CHECKED, PLEASE GIVE A BRIEF EXPLANATION OF CIRCUM-STANCES. PLEASE LIST ALL ATTEMPTS TO CONTACT PATIENT BY DATE, METHOD AND RESULT.)

DESCRIBE PROGRESS AS IT RELATES TO ORIGINAL TREATMENT PLAN.

_____

_____

ACCORDING TO MY RECORDS THE PATIENT IS:

KEEPING HIS / HERS APPOINTMENTS YES [ ] NO [ ]

PRACTICING GOOD ORAL HYGIENE YES [ ] NO [ ]

TAKING CARE NOT TO BREAK THE ORTHODONTIC APPLIANCES YES[ ] NO[ ]

_____

SIGNATURE OF ORTHODONTIST

_____

6 MONTH PROGRESS PRIOR AUTHORIZATION NUMBER

MAP- 700 (REV. 12/95)

KENTUCKY MEDICAID PROGRAM
ORTHODONTIC FINAL CASE SUBMISSION

RECIPIENT NAME_____

MEDICAID I.D. #_____

DOCTORS NAME_____ PROVIDER #_____

DATE OF BANDING_____ FINISHED DATE_____

COPY OF BEGINNING AND FINAL RECORDS ENCLOSED- YES [ ] NO [ ]

IF NO EXPLAIN_____

WAS TREATMENT COMPLETED ACCORDING TO ORIGINAL TREATMENT PLAN

SUBMITTED ? YES [ ] NO [ ] IF NO EXPLAIN_____

_____

_____

DID THE PATIENT COMPLY WITH TREATMENT PLAN ?YES [ ] NO [ ]

IF NO EXPLAIN-_____

_____

WAS ORTHODONTIC SURGERY PART OF TREATMENT ? YES [ ] NO [ ]

IF YES, WHAT PROCEDURE WAS PERFORMED?_____

DOES THE PROVIDER CONSIDER THE RESULTS EXCELLENT [ ]

SATISFACTORY [ ] POOR [ ] INCOMPLETE [ ]

EXPLAIN_____

_____

PROVIDERS TOTAL FEE (FOR TREATMENT)_____

_____
SIGNATURE

_____
DATE

PRIOR- AUTHORIZATION NUMBER
INITIAL SUBMISSION_____
SIX MONTH REPORT_____
FINAL CASE_____